GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

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SENATE DRS65150-LN-92* (3/20)

Short Title:	Managed Care Patient Assistance.	(Public)
Sponsors:	Senator Clodfelter.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REQUIRE INSURERS TO INFORM COVERED PERSONS ABOUT ASSISTANCE AVAILABLE FROM THE MANAGED CARE PATIENT ASSISTANCE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-61(h), (k), and (m) read as rewritten:

"**§ 58-50-61. Utilization review.**

…

(h) Notice of Noncertification. – A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. An insurer shall provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request. An insurer shall also inform the covered person in writing about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

…

(k) Nonexpedited Appeals. – Within three business days after receiving a request for a standard, nonexpedited appeal, the insurer shall provide the covered person with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, the insurer shall give written notification of the decision, in clear terms, to the covered person and the covered person's provider within 30 days after the insurer receives the request for an appeal. If the decision is not in favor of the covered person, the written decision shall contain:

(1) The professional qualifications and licensure of the person or persons reviewing the appeal.
(2) A statement of the reviewers' understanding of the reason for the covered person's appeal.
(3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.
(4) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.
(5) A statement advising the covered person of the covered person's right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under G.S. 58-50-62.
(6) Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

…

(m) Disclosure Requirements. – In the certificate of coverage and member handbook provided to covered persons, an insurer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for appealing noncertifications and a statement of the rights and responsibilities of covered persons, including the voluntary nature of the appeal process, with respect to those procedures. An insurer shall also include in the certificate of coverage and the member handbook information about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program. An insurer shall include a summary of its utilization review procedures in materials intended for prospective covered persons. An insurer shall print on its membership cards a toll-free telephone number to call for utilization review purposes."

SECTION 2.(a) G.S. 58-50-62(c) reads as rewritten:

"(c) Grievance Procedures. – Every insurer shall have written procedures for receiving and resolving grievances from covered persons. A description of the grievance procedures shall be set forth in or attached to the certificate of coverage and member handbook provided to covered persons. The description shall include a statement informing the covered person that the grievance procedures are voluntary and shall also inform the covered person about the availability of the Commissioner's office for assistance, including the telephone number and address of the office. The description shall also inform the covered person about the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program."

SECTION 2.(b) G.S. 58-50-62(e)(2) reads as rewritten:

"(e) First-Level Grievance Review. – A covered person or a covered person's provider acting on the covered person's behalf may submit a grievance.

…

(2) An insurer shall issue a written decision, in clear terms, to the covered person and, if applicable, to the covered person's provider, within 30 days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. Except as provided in subdivision (3) of this subsection, if the decision is not in favor of the covered person, the written decision issued in a first-level grievance review shall contain:

a. The professional qualifications and licensure of the person or persons reviewing the grievance.

b. A statement of the reviewers' understanding of the grievance.

c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the covered person to respond further to the insurer's position.

d. A reference to the evidence or documentation used as the basis for the decision.

e. A statement advising the covered person of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance under this section.

f. Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program."

SECTION 2.(c) G.S. 58-50-62(f)(1) reads as rewritten:

"(f) Second-Level Grievance Review. – An insurer shall establish a second-level grievance review process for covered persons who are dissatisfied with the first-level grievance review decision or a utilization review appeal decision. A covered person or the covered person's provider acting on the covered person's behalf may submit a second-level grievance.

…

(1) An insurer shall, within 10 business days after receiving a request for a second-level grievance review, make known to the covered person:

a. The name, address, and telephone number of a person designated to coordinate the grievance review for the insurer.

b. A statement of a covered person's rights, which include the right to request and receive from an insurer all information relevant to the case; attend the second-level grievance review; present his or her case to the review panel; submit supporting materials before and at the review meeting; ask questions of any member of the review panel; and be assisted or represented by a person of his or her choice, which person may be without

limitation to: a provider, family member, employer representative, or attorney. If the covered person chooses to be represented by an attorney, the insurer may also be represented by an attorney.

c. The availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program.

…"

SECTION 2.(d) G.S. 58-50-62(h) reads as rewritten:

"(h) Second-Level Grievance Review Decisions. – An insurer shall issue a written decision to the covered person and, if applicable, to the covered person's provider, within seven business days after completing the review meeting. The decision shall include:

(1) The professional qualifications and licensure of the members of the review panel.

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.

(3) The review panel's recommendation to the insurer and the rationale behind that recommendation.

(4) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.

(5) In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.

(6) The rationale for the insurer's decision if it differs from the review panel's recommendation.

(7) A statement that the decision is the insurer's final determination in the matter. In cases where the review concerned a noncertification and the insurer's decision on the second-level grievance review is to uphold its initial noncertification, a statement advising the covered person of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance.

(8) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

(9) Notice of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program."

SECTION 3. G.S. 58-50-80(b)(3) reads as rewritten:

"**§ 58-50-80. Standard external review.**

…

"(b) Upon receipt of a request for an external review under subsection (a) of this section, the Commissioner shall, within 10 business days, complete all of the following:

…

(3) Notify in writing the covered person and the covered person's provider who performed or requested the service whether the request is complete and whether the request has been accepted for external review. If the request is complete and accepted for external review, the notice shall include a copy of the information that the insurer provided to the Commissioner pursuant to subdivision (b)(1) of this section, and inform the covered person that the covered person may submit to the assigned independent review organization in writing, within seven days after the receipt of the notice, additional information and supporting documentation relevant to the initial denial for the organization to consider when conducting the external review. If the covered person chooses to send additional information to the assigned independent review organization, then the covered person shall at the same time and by the same means, send a copy of that information to the insurer. The Commissioner shall also notify the covered person in writing of the availability of assistance from the Managed Care Patient Assistance Program, including the telephone number and address of the Program."

SECTION 4. This act becomes effective October 1, 2003, and applies to actions taken by the insurer under the subsections of G.S. 58-50-61, 58-50-62, and 58-50-80 amended by this act, on and after that date. G.S. 58-50-61, as amended by this act, applies to member handbooks printed after October 1, 2003.